



Medical Coding

Essential guidelines & tips to core coding procedures & practices, including: ICD-10-CM, CPT-4 & HCPCS Level II

General Coding & Legal Guidelines

Medical Care & Preventative Care in Health Care

- Health care is a comprehensive system that focuses on establishing and maintaining each individual's good health.
- Third-party payer is the person or organization not involved in the health care relationship except for their obligation to pay for the encounter and services rendered.
 - Party #1: The health care provider
 - Party #2: The patient
 - Party #3: The insurance carrier (third-party payer)
- ICD-10-CM stands for International Classification of Diseases, 10th Revision, Clinical Modification
- ICD-10-CM used to code diagnosis
- ICD-10-PCS contains codes used to bill for inpatient hospital procedures
- CPT stands for Current Procedural Terminology and is used to code procedures
- HCPCS stands for Health Care Common Procedural Coding System
- HCPCS Level II is a book containing codes used to bill for dental procedures, durable medical equipment (DME), drugs, and other services and supplies; codes are used to report services, procedures, and supplies not included in CPT
 - Advanced Life Support (ALS) is a level of service provided by ambulatory personnel
 - Durable Medical Equipment, Prosthetics, and Orthotics (DMEPOS)
- Durable Medical Equipment (DME) medical supplies that either can be used by several individuals or that last a long time, such as pumps or a wheelchair
- Outpatient: an individual provided health care services without an overnight stay in the facility
- Inpatient: an individual staying overnight in an acute-care or other health care facility

Legal Guidelines

- HIPAA, Health Insurance Portability and Accountability Act, is federal law

TIP If you don't know, you don't code. Don't assume. Don't guess. Don't invent.

- HIPAA's Privacy Rule is about protecting the patient's privacy; this law simply ensures each and every person coming to any health care facility that their personal and private information will be protected and treated with respect
- Coding for coverage means that a code is changed to fit what the insurance company will pay for rather than accurately reflecting the procedure that was performed
- Medical necessity (medically necessary) is the determination that the provider was acting according to standard practice in providing the procedure for an individual with the diagnosis; use of ICD-10-CM Diagnostic Codes constitutes a medical reason (medical necessity) for providing the services and/or procedures claimed
- Mutually exclusive codes report conditions that cannot be in the same patient at the same time
- Supporting documentation refers to the paperwork in the patient's file that corroborates the codes presented on the claim form for that particular encounter
- Unbundling means that individual parts of a specific procedure were used rather than a combination or bundle that includes all those components
- Upcoding means that a code is used on a claim form indicating a higher level of service than was actually performed

Rules of Legal & Ethical Coding

- The codes indicated on the claim form must represent the services actually performed and are supported by the notes and other documentation in the patient's health record
- Coding for coverage—using codes not chosen for the best, most accurate code available, but rather, with regard to what procedure the insurance company will pay for (i.e., "cover")—is dishonest and is considered **fraud**
- Upcoding—using a code that indicates that a higher level of service was provided than was actually performed—is unethical and **illegal**
- Submitting a claim for services that have already been billed for is called double billing and is considered **fraud**
- Unbundling—using individual (also known as

- component) service codes when a comprehensive or combination bundled code is available—is **illegal**
- The use of mutually exclusive codes—codes identified as not permitted to be used on the same claim form—is considered **unethical**
- Reporting codes relating to a single encounter and placing them on several claim forms over the course of several days is **not legal or ethical**

Definitions

TIP

Steps to Accurate Coding

1. Read through the hospital and the physician's notes
2. Ask the physician's notes
3. Query the health care provider if codes are missing or unclear
4. Code the diagnosis
5. Code the procedure
6. List every procedure only in a way that diagnosis code is document medical necessity



Methods of Administering Medications

- IA Intracranial (into the artery)
- ID Intradermal (skin test)
- IM Intramuscular (into the muscle)
- IN Inhalation (breathed in by the patient)
- IO Intravenous (into the blood)
- IP Intraperitoneal (into the abdominal wall)
- IT Intrathecal (into spinal fluid)
- IV Intravenous (into the vein)
- ORAL Orally (by mouth)
- OTH Other routes, suppositories, catheter, injections, etc.
- SC Subcutaneous (below the surface of the skin)
- Subj Sublingual
- VAG Vaginal (includes administration into penis, vagina, uterus, or topical applications)

- CLIA: Clinical Laboratory Improvement Amendments, federal legislation created for the monitoring and regulation of clinical procedures
- SHAD: Early and Periodic Screening, Diagnostic, and Treatment services, a Medicaid preventive health program for children under 21 years of age
- HIPAA: Health Professional Shortage Area
- License Termination: physician that file is, temporarily, for another physician

TIP

- Use a medical dictionary to ensure you know what the terms mean
- Always double-check your notations to provide you the correct code

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CODING TIPS

ABC123	Never code out of the Alphabetic Index
Back Coding	After coding a patient's encounter from the physician's notes, make certain you look code to double-check your work, run a code while, then go into the ICD-10-CM Tabular List and into the CPT numerical listing, and look up the codes you found earlier; match the descriptions you see to the key words from the physician's notes; this may help you find any errors
CC	Chief Complaint: concise statement about the reason for the encounter
Medical Record Documentation	The records for each patient encounter should include: - Reason for encounter and relevant history, physical exam findings, and prior diagnostic test results - Assessment, clinical impressions, another diagnosis - Plan for care - Date and legible identity of observer or provider
Who = The Patient	Why did the patient come to see the provider?
Why = Diagnosis Code(s)	What did the provider do in response to the "why"?
What = Procedure Code(s)	How did the injury or poisoning happen?
How = External Cause Code	Where did it happen?

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